DEPARTMENT OF HEALTH AND HUM		FORM	
CENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SU
AND DE AN OF CORRECTION	IDENTIFICATIONAL HARDED	0.4	COLUBITE

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155766		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 07/21/2011
MAPLE	PROVIDER OR SUPPLIE		643 WI	ADDRESS, CITY, STATE, ZIP COE EST UTICA ST :RSBURG, IN47172	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL SLESC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION
K0000	State Licensure the Indiana State accordance with Survey Date: 0° Facility Number Provider Number AIM Number: 1° Surveyor: Mark Specialist At this Life Safe Manor Christian Division was for with Requireme Medicare/Medic 483.70(a), Life 3° 2000 edition of Protection Assoc Safety Code (LS The original bui Chapter 19, Exist Occupancies. This one story fawas determined construction and facility has a fire	r: 000563 rr: 155766	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H9JJ21

Facility ID:

TITLE

000563

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		155766	B. WING		07/21/2011
	ROVIDER OR SUPPLIER		643 WE	ADDRESS, CITY, STATE, ZIP CODE EST UTICA ST RSBURG, IN47172	
(X4) ID		TATEMENT OF DEFICIENCIES	I ID	1	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
K0046 SS=E	smoke detection Hall resident roo capacity of 57 an the time of this v Quality Review by I Code Specialist-Med The facility was with the aforeme requirements as of following: Emergency lighting duration is provide 19.2.9.1. Based on observa facility failed to o backup lights we the past year and ensure the light v during periods of 52 of 52 resident a functional test of every required er at 30 day interval seconds. An ann conducted on ever powered emergen not less than 1 1/ shall be fully ope of the test. Writt	Robert Booher, Life Safety dical Surveyor on 07/27/11. found not in compliance intioned regulatory evidenced by the g of at least 1½ hour in accordance with 7.9. Ation and interview, the ensure 2 of 2 battery in tested monthly over had annual tests to evould provide lighting and provide lighting system are gency lighting system and provide lighting system are gency lighting system as for not less than 30	K0046	The deficient practice of not testing of 3 of 3 backup lights monthly and annually will be corrected by the maintenance department. The maintenance supervisor or his designee we test the batteries monthly for seconds and annually for 1 1 hours. The maintenance supervisor or his designee we keep written records of those testings.	e ce ill 30 /2

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155766		(X2) MUI A. BUILD B. WING		STRUCTION 01	(X3) DATE S COMPLI 07/21/20	ETED	
	PROVIDER OR SUPPLIER			643 WES	DDRESS, CITY, STATE, ZIP CODE ST UTICA ST SBURG, IN47172		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	having jurisdiction	tion by the authority on. This deficient Il residents in the facility.					
	Findings include:						
	p.m. with the adr maintenance sup- emergency gener had two battery be the wall near the on an interview v supervisor on 07/ two basement tra- battery powered tested monthly of ninety minute du	ation on 07/21/11 at 1:45 ministrator and ervisor, the basement rator transfer switch room backup lights mounted on transfer switch. Based with the maintenance /21/11 at 1:55 p.m., the msfer switch room backup lights are not r tested annually for a rration. This was verified attor at the time of the					
K0052 SS=F	installed, tested, a accordance with N Code and NFPA 7 approved mainten	IFPA 70 National Electrical 2. The system has an ance and testing program plicable requirements of					
	facility failed to conducted over the	review and interview, the ensure 12 of 12 fire drills he past year included the fire alarm signal to	K00	052	The deficient practice of not indicating that the alarm was activated during fire drills was corrected on 7/29/2011. The administrator added a space		07/29/2011

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			01	COMPI	
		155766		LDING		07/21/2	011
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER		1	ST UTICA ST		
MADIEN	MANOR CHRISTIA	N HOME INC		1	RSBURG, IN47172		
				<u> </u>	N3BUNG, 11147 172		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	protect 52 of 52 residents. NFPA 72,				the fire drill report sheet to		
	National Fire A	lrm code, in Table 7-3.2,			indicate that the alarm was sounded during fire drills. T	-ho	
	Testing Frequer	ncies, at number 23			administrator or his designe		
	requires monthl	y testing of the			continue to monitor every fi		
		tion Fire Alarm Systems			that is conducted to ensure		
	1 1	deficient practice could			the activation of the alarm is	3	
		nts in the facility.			recorded.		
		its in the facility.					
	Findings include:						
	Findings includ	6.					
	Based on a revi	ew of the "Fire Drill Log"					
		administrator and					
	1 ^	pervisor on 07/21/11 at					
		welve fire drills conducted					
	1	ar did not indicate the fire					
	1 *	as activated during each					
	fire drill conduc	eted. Based on an					
	interview with t	the maintenance supervisor					
	on 07/21/11 at 2	2:05 p.m., the fire alarm					
	system is usuall	y activated during daytime					
	1 -	documented on the Fire					
		ts. This was verified by					
		or at the time of interview.					
	die administrati	of the time of filterview.					
	3.1-19(b)						
	J.1-17(0)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H9JJ21

Facility ID: 000563

If continuation sheet

PRINTED: 08/10/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155766	A. BUII	LDING	01	COMPL 07/21/2	ETED
		1.007.00	B. WIN			0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· · ·
	PROVIDER OR SUPPLIER			643 WE	DDRESS, CITY, STATE, ZIP CODE ST UTICA ST RSBURG, IN47172		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0056 SS=E	installed in accord Standard for the Ir Systems, to provious portions of the built properly maintaine 25, Standard for the Maintenance of W. Systems. It is fully reliable, adequate system. Required equipped with wat switches, which are the building fire also Based on observing facility failed to with combustible provided with sp. 13, 1999 Edition, sprinklers shall be exterior combustible exceeding four feed deficient practice reside on the 300 300 Hall east exiconnected by the Service Hall exit. Findings include Based on observation at our of the facing 2:20 p.m. with the maintenance supplexit porch overhall exit.	ation and interview, the ensure 2 of 4 porches e overhangs were rinkler coverage. NFPA 5-13.8.1 requires installed under ole roofs or canopies et in width. This e affects 18 residents who hall and would use the t for evacuation, which is a same porch as the	K	0056	The deficient practice of not having 2 of 4 porches with combustible overhangs prov with sprinkler coverage. Koo Fire and Security Systems haven called and they are scheduled to come to the fact on August 11, 2011 to evaluate what is needed to provide on the porches with sprinkler coverage. The second porch been altered according to the regulations of the Life Sa The second porch overhang shorter than the required 4 fe and does not now need to have sprinkler coverage.	orsen ave cility ate ne of n has afety. is eet	08/20/2011

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Event ID:

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Facility ID:

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PRINTED: 08/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155766		A. BUIL	DING	NSTRUCTION 01	(X3) DATE S COMPL 07/21/20	ETED		
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE ST UTICA ST RSBURG, IN47172	07721720		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
	had a three foot proverbang not procoverage because between the spring edge of the build which extended by Furthermore, the overbang, which quarter inch twick supervisor, was a sprinkler coverage of the two porches soffit on 07/21/11 administrator and it was verified the	portion of the porch vided with sprinkler e of a two foot bulkhead akler five feet from the ing and the bulkhead, below the sprinkler. kitchen exit porch a measured four feet one the by the maintenance not provided with the Based on observation the construction above the at at 11:55 a.m. with the d maintenance supervisor, the porches are constructed the porches are						
K0061 SS=F	valves supervised alarm will sound w NFPA 72, 9.7.2.1 Based on observation facility failed to esprinkler system supervised so at 1 sound when the value of the supervi	c sprinkler systems have so that at least a local then the valves are closed. ation and interview, the ensure 1 of 1 automatic post indicator valves was least a local alarm will valve is closed. This eaffect all residents in the	K0	061	The deficent practice of not ensuring the automatic sprint system post indicator valve we supervised by a local alarm whose corrected by Koorsen Fire Security Systems. Koorsen I and Security is scheduled to come to the facility on Augus 2011 to assess what will be needed in order to correct the deficient practice. The	/as vill and Fire t 11,	08/20/2011	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CON	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155766	B. WING			07/21/20	011
			D. 11111		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ST UTICA ST		
MAPLE N	MANOR CHRISTIAN	N HOME INC			SBURG, IN47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Based on observation on 07/21/11 at 11:45 a.m. with the administrator and maintenance supervisor, the automatic sprinkler system post indicator valve located outside the front entrance to the facility along the city street was not provided with an electrical connection to the fire alarm system or an electrical connection causing a local alarm to sound when the valve is closed. Based on observation of the fire alarm system main panel on 07/21/11 at 12:20 p.m. with the administrator and maintenance supervisor, it was further verified the post indicator valve was not listed on the fire alarm system zone label. This was confirmed by the administrator and maintenance supervisor at the time of observations.				Administrator will monitor the work and make sure it is completed.		
	3.1-19(b)						
K0144 SS=F	exercised under lomonth in accordar 3.4.4.1.		•				
	the facility failed emergency gener a functional alarr location readily of personnel at a reg a nurses' station.	ervation and interview, to ensure 1 of 1 rators was provided with m annunciator in a observed by operating gular work station such as NFPA 99, Health Care 1.15 requires a remote	K0	144	The deficient practice of not ensuring that the emergency generatior was provided with functional alarm annunciator 24 hour nurse station will be corrected by Crosspoint Cummings. Crosspoint Cummings will be respondisil for installing a functional alarmannunciator at a 24 hour nurse.	a in a ble m	08/20/2011

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Event ID:

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Facility ID:

000563 If co

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155766		A. BUI	LDING	NSTRUCTION 01	(X3) DATE S COMPL 07/21/20	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST UTICA ST RSBURG, IN47172		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	annunciator, storshall be provided generating room observed by open regular work stat shall indicate alaremergency or autifollows: (a) Individual visional indicate in the emergency of autifollows: (a) Individual visional indicate in the emergency of autifollows: (b) Individual visional indicate in the emergency or autifollows: (b) Individual visional indicate in the emergency of autifolic in the emergency of the individual visional indicate in the emergency in the emerg	age battery powered, I to operate outside of the in a location readily rating personnel at a ion. The annunciator rm conditions of the exiliary power source as sual signals shall indicate: rgency or auxiliary operating to supply power ery charger is sual signals plus a signal to warn of an alarm condition shall ag oil pressure. her temperature. er temperature. er the main fuel storage is than a 3-hour operating led to start). work station will be dically, an audible and ent signal, appropriately			station. The work will be don'the week of August 15-19, 2011. The deficient practice of having an emergency shut of the generator has been resordue to the fact that the enging the generator is only a 47 horsepower engine. There is letter from Cummings Cross that states that fact. The Administrator will make sure the corrective action will be completed.	of not ff for lved ne for s a point	

000563

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155766	B. WIN	G		07/21/2	011
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	EST UTICA ST		
MAPLE I	MANOR CHRISTIAI	N HOME INC		SELLER	RSBURG, IN47172		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		idually. This deficient					
	1 ^	fect all the residents as					
	well as visitors a	and staff.					
	Findings include	»:					
	Based on observ	ation on 07/21/11 at					
		the administrator and					
		pervisor, a remote alarm					
	_	the generator was					
		pasement next to the					
	_	rator transfer switch.					
	Based on an inte						
		07/21/11 at 10:50 a.m.,					
		annunciator for the					
		rator cannot be readily					
	1	f during all shifts.					
	observed by star	i during an sinits.					
	3.1-19(b)						
	2. Based on ob	servation and					
	interview, the f	acility failed to ensure 1					
		y generators with over					
		wer was equipped with					
	•	ıal stop. LSC 7.9.2.3					
		gency generators					
		er to emergency lighting					
	l .	pe installed, tested and					
	1 -	accordance with NFPA					
	110, Standard	for Emergency and					
		r Systems. NFPA 110,					
	1	-5.5.6 requires Level I					
	1	all have a remote					
	manual stop st	ation of a type similar					
	·	-					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155766	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE: COMPL 07/21/2	ETED
	PROVIDER OR SUPPLIER		•	643 WE	DDRESS, CITY, STATE, ZIP CODE ST UTICA ST RSBURG, IN47172	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	outside the roomover. NFPA 3 Installation and Combustion Entrubines, 1998 requires engine or more have produced to the generator set is kilowatt diesel generator set	Edition, at 8-2.2(c) es of 100 horsepower rovision for shutting e at the engine and ocation. This deficient affect all residents. e: rvation of the nerator with the nd maintenance 17/21/11 at 1:10 p.m., et nameplate did not resepower rating of the The generator was not a remote manual stop on an interview with the supervisor on 5 p.m., the emergency is a two hundred forty generator and is					
K0000							

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	04	COMPL	ETED
		155766	B. WIN			07/21/2	011
			-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		643 WE	EST UTICA ST		
	MANOR CHRISTIAI				RSBURG, IN47172		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	A Life Safety Code Recertification and		17.0	TAG	BEI ICIENCI)		DATE
	1		K	0000			
		Survey was conducted by					
		Department of Health in					
	accordance with	42 CFR 483.70(a).					
	Survey Date: 07	7/21/11					
	Facility Number	: 000563					
	Provider Numbe						
	AIM Number: 1						
	Surveyor: Mark Bugni, Life Safety Code Specialist						
	At this Life Safe	ty Code survey, Maple					
	Manor Christian	Home Inc. Adult					
	Division was for	and not in compliance					
	with Requiremen	nts for Participation in					
	1	aid, 42 CFR Subpart					
		Safety from Fire and the					
	2000 edition of t	_					
		ciation (NFPA) 101, Life					
		C) and 410 IAC 16.2.					
	1 ' '	Room addition was					
		hapter 18, New Health					
	Care Occupancie	-					
	Care Occupancio	J.S.					
	This 2011 addition	on to the one story facility					
		was determined to be of					
		nstruction and fully					
	1 ** ` ′	e facility has a fire alarm					
	_	oke detection in the					
	1 -						
		s open to the corridors,					
	and single station	n smoke detection in the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
155766		- 1	A. BUILDING 04			COMPLETED 07/21/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			643 WE	EST UTICA ST		
MAPLE I	MANOR CHRISTIAN	N HOME INC		SELLER	RSBURG, IN47172		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
K0014 SS=F	100 Hall and 200 The facility has a census of 52 at the sensus of	orridors and exitways, interior surfaces of fixed or movable walls, is, and ceilings, has a flame lass A or Class B. Lower rewalls can be Class C. Action and interview, the ensure 1 of 1 corridor's is had a flame spread and the corridor's contact affects all residents family visitor rooms in the facility.	K	TAG	The deficient practice of not covering the corridor's wall interior finish with a flame sprating covering of Class A, CB or Class C will be correcte covering the corridor's wall will make spread covering. The maintenance department will apply the flame spead cover Class A, Class B, or Class C the wood paneling. The administration will make sure that the correction is taken.	read lass d by vith a ing on	DATE 08/20/2011

AND PLAN OF CORRECTION IDEN		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155766	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 04	(X3) DATE SURVEY COMPLETED 07/21/2011
NAME OF PROVIDER OR SUPPLIER MAPLE MANOR CHRISTIAN HOME INC			STREE 643 V	T ADDRESS, CITY, STATE, ZIP CODE VEST UTICA ST ERSBURG, IN47172	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0015 SS=F	supervisor on 07, there was no doc paneling had a fl Class A, Class E finish. 3.1-19(b) Interior finish for refor corridors or eximple walls, panelings has a flamor Class B. (Room capacity may have Class A Class B, Class A Class B, This deresidents who userooms in the new had a flame spread Class B. This deresidents who userooms in the new Findings include Based on observation of the companion of the new wood paneling in the pool of the companion of th	ation and interview, the ensure the walls in 2 of 2 portion of the facility and rating of Class A or ficient practice affects all the two family visitor portion of the facility.	K0015	The deficient practice of not covering the 2 room walls int finish with a flame spread rat covering of Class A, Class B Class C will be corrected by covering the 2 room walls wit flame spread covering. The maintenance department will apply the flame spead cover Class A, Class B, or Class C the wood paneling. The administrator will make sure that the corrected action is taken.	ting or th a l ing on

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Event ID:

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Facility ID:

000563

If continuation sheet

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		IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
155766			A. BUILDING	04	07/21/2011	
100700		B. WING	ADDRESS, CITY, STATE, ZIP CODE	0172172011		
NAME OF P	ROVIDER OR SUPPLIER			EST UTICA ST		
MAPLE N	MANOR CHRISTIAN	N HOME INC		RSBURG, IN47172		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
IAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE	DATE	
		e administrator and				
	•	ervisor on 07/21/11 at				
		room has a capacity of				
	twenty people an					
		ne wood paneling had a				
		ng of a Class A or Class				
	B interior finish.					
	3.1-19(b)					
K0046 SS=E		g of at least 1½ hour ed in accordance with 7.9.				
	Based on observa	ation and interview, the	K0046	The deficient practice of not		
	facility failed to	ensure 3 of 3 battery		testing of 3 of 3 backup ligh monthly and annually will be		
	backup lights we	re tested monthly over		corrected by the maintenan		
	the past year and	had annual tests to		department. The maintenance		
	ensure the light v	vould provide lighting		supervisor or his designee		
	during periods of	f power outages to protect		test the batteries monthly for		
	52 of 52 resident	s. Section 7.9.3 requires		seconds and annually for 1 hours. The maintenance	1/2	
	a functional test s	shall be conducted on		supervisor or his designee	will	
	every required er	nergency lighting system		keep written records of thos	se	
	at 30 day interval	ls for not less than 30		testings.		
	seconds. An ann	ual test shall be				
	conducted on eve	ery required battery				
	powered emerger	ncy lighting system for				
		2 hours. Equipment				
		erational for the duration				
		en records of visual				
	inspections and tests shall be kept by the					
	_	tion by the authority				
	•	on. This deficient				
		ll residents in the facility.				
		··· · , ·				

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155766	A. BUILDING	E CONSTRUCTION 04	(X3) DATE SURVEY COMPLETED 07/21/2011
	PROVIDER OR SUPPLIER		643	ET ADDRESS, CITY, STATE, ZIP CODE WEST UTICA ST LERSBURG, IN47172	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	Findings include	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE
	p.m. with the adr maintenance sup- emergency gener had two battery be the wall near the Family Visitor Re- battery backup li- exit door. Based maintenance sup- 1:55 p.m., the thi- backup lights are tested annually for duration. This w	ation on 07/21/11 at 1:45 ministrator and ervisor, the basement ator transfer switch room backup lights mounted on transfer switch and the boom addition had one ght mounted above the on an interview with the ervisor on 07/21/11 at the battery powered not tested monthly or or a ninety minute as verified by the he time of the interview.			
K0052 SS=F	installed, tested, a accordance with N Code and NFPA 7 approved mainten complying with ap NFPA 70 and 72. Based on record facility failed to conducted over the transmission of a protect 52 of 52 m National Fire Alm	FPA 70 National Electrical 2. The system has an ance and testing program blicable requirements of	K0052	The deficient practice of not indicating that the alarm was activated during fire drills was corrected on 7/29/2011. The administrator added a space the fire drill report sheet to indicate that the alarm was sounded during fire drills. Th administrator or his designee	to e

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155766		IDENTIFICATION NUMBER:		JLTIPLE CON LDING	NSTRUCTION 04	(X3) DATE SURVEY COMPLETED 07/21/2011	
		B. WIN	G		07/21/2	011	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ST UTICA ST		
MAPLE N	MANOR CHRISTIAN	I HOME INC		SELLER	SBURG, IN47172		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG	requires monthly			IAG	continue to monitor every fire	drill	DATE
	1 1	ion Fire Alarm Systems			that is conducted to ensure the		
	1	ficient practice affects all			the activation of the alarm is		
		family visitor rooms in the			recorded.		
	Findings include:						
	with the administrat on 07/21/11 at 1:50 conducted over the p fire alarm system wadrill conducted. Bas maintenance supervithe fire alarm systen daytime drills but is	of the "Fire Drill Log" reports or and maintenance supervisor p.m., the twelve fire drills past year did not indicate the as activated during each fire sed on an interview with the isor on 07/21/11 at 2:05 p.m., in is usually activated during not documented on the Fire this was verified by the time of interview.					
	3.1-19(b)						
K0061 SS=F	valves supervised alarm will sound w NFPA 72, 9.7.2.1 Based on observation facility failed to esprinkler system supervised so at a sound when the value of the supervised so at a sound when the supervised so at a	ic sprinkler systems have so that at least a local when the valves are closed. ation and interview, the ensure 1 of 1 automatic post indicator valves was least a local alarm will walve is closed. This e affect all residents using	K0	0061	The deficent practice of not ensuring the automatic sprint system post indicator valve we supervised by a local alarm where the corrected by Koorsen Fire Security Systems. Koorsen I and Security is scheduled to come to the facility on Augus	vas vill e and Fire	08/20/2011
	the two family visitor rooms in the new				2011 to assess what will be	ί ΙΙ,	
	portion of the fac	eility.			needed in order to correct the	e	
	Findings include:				deficient practice. The Administrator will monitor the work and make sure it is completed.	,	
	Based on observa	ation on 07/21/11 at			,		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 04 A. BUILDING 155766 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 643 WEST UTICA ST MAPLE MANOR CHRISTIAN HOME INC SELLERSBURG, IN47172 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 11:45 a.m. with the administrator and maintenance supervisor, the automatic sprinkler system post indicator valve located outside the front entrance to the facility along the city street was not provided with an electrical connection to the fire alarm system or an electrical connection causing a local alarm to sound when the valve is closed. Based on observation of the fire alarm system main panel on 07/21/11 at 12:20 p.m. with the administrator and maintenance supervisor, it was further verified the post indicator valve was not listed on the fire alarm system zone label. This was confirmed by the administrator and maintenance supervisor at the time of observations. 3.1-19(b)K0144 Generators are inspected weekly and exercised under load for 30 minutes per SS=F month in accordance with NFPA 99. 3.4.4.1. The deficient practice of not K0144 08/20/2011 1. Based on observation and interview. ensuring that the emergency the facility failed to ensure 1 of 1 generatior was provided with a emergency generators was provided with functional alarm annunciator in a a functional alarm annunciator in a 24 hour nurse station will be corrected by Crosspoint location readily observed by operating Cummings. Crosspoint personnel at a regular work station such as Cummings will be respondisible a nurses' station. NFPA 99, Health Care for installing a functional alarm Facilities, 3-4.1.1.15 requires a remote annunciator at a 24 hour nurse station. The work will be done annunciator, storage battery powered, the week of August 15-19, shall be provided to operate outside of the 2011. The deficient practice of not generating room in a location readily having an emergency shut off for 000563

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY			
		IDENTIFICATION NUM	MBER:	A. BUIL	DING	04		COMPL	
		155766		B. WIN				07/21/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STAT	ΓE, ZIP CODE			
						ST UTICA ST			
MAPLE N	MANOR CHRISTIAN	N HOME INC			SELLEF	RSBURG, IN4717	72		
(X4) ID		TATEMENT OF DEFICIE			ID		AN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDE			PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INF		+	TAG		has been resol	ved	DATE
		rating personnel a				-	t that the engine		
	~	ion. The annunci				the generator	is only a 47		
							ngine. There is		
	follows:	xiliary power sou	ice as			that states that	mmings Crossp	ooint	
			:d:				will make sure	that	
	` ′	sual signals shall i				the corrective			
		rgency or auxilian	-			completed.			
	1 ^	operating to suppl	y power						
	to load.								
	2. When the batte	ery charger is							
	malfunctioning.	1 . 1 1							
	` ′	sual signals plus a							
		signal to warn of							
		alarm condition	shall						
	indicate:								
	1. Low lubricatin	• .							
	2. Low water tem	•							
	3. Excessive water	•							
		en the main fuel s	-						
		s than a 3-hour op	perating						
	supply.								
	5. Overcrank (fai	iled to start).							
	6. Overspeed.		_						
		work station will							
	1	dically, an audible							
		ent signal, approp	riately						
	labeled, shall be								
	continuously monitored location. This								
	derangement signal shall activate when								
	any of the conditions in 3-4.1.1.15(a) and								
	(b) occur but need not display these								
		dually. This defic							
	_	fect all the resider							
	using the two fan	nily visitor rooms	s in the						
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155766		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 04	(X3) DATE: COMPL 07/21/2	ETED	
NAME OF PROVIDER OR SUPPLIER MAPLE MANOR CHRISTIAN HOME INC			•	643 WE	.DDRESS, CITY, STATE, ZIP CODE ST UTICA ST RSBURG, IN47172	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	new portion of the visitors and staff	ne facility as well as					
	Findings include	:					
	Based on observation on 07/21/11 at 10:45 a.m. with the administrator and maintenance supervisor, a remote alarm annunciator for the generator was provided in the basement next to the emergency generator transfer switch. Based on an interview with the administrator on 07/21/11 at 10:50 a.m., the remote alarm annunciator for the emergency generator cannot be readily observed by staff during all shifts. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator with over a 100 horsepower was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155766		A. BUI	LDING	04 	COMPI 07/21/2	ETED		
		100/00	B. WIN			07/21/2	UII	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
MADIEA	AANOD OUDIOTIAA	LUOMEINO			ST UTICA ST			
MAPLE	MANOR CHRISTIAN	N HOME INC		SELLER	RSBURG, IN47172			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		m housing the prime						
		37, Standard for the						
		Use of Stationary						
	Combustion En	_						
		Edition, at 8-2.2(c)						
		es of 100 horsepower						
	•	rovision for shutting						
	_	e at the engine and						
		ocation. This deficient						
	practice could a	affect all residents						
	using the two fa	amily visitor rooms in						
	the new portion of the facility.							
	Findings include	e:						
	Based on obse	rvation of the						
	emergency gen							
		nd maintenance						
		7/21/11 at 1:10 p.m.,						
	•	et nameplate rating						
	_							
		e the horsepower nerator set and was						
		ith a remote manual						
	-	ased on an interview						
		nance supervisor on						
		5 p.m., the emergency						
	_	a two hundred forty						
		generator and is						
	probably over o							
	•	his was verified by the						
	administrator at	t the time of interview.						
	3-1.19(b)							
	- (3)							

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CENTERS FOR MEDICARD SERVICES								
STATEM	IENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER:		04		COMPLETED		
		155766	A. BUILDING B. WING			07/21/2	011	
NAME OF PROVIDER OR SUPPLIER MAPLE MANOR CHRISTIAN HOME INC				643 WE	ADDRESS, CITY, STATE, ZIP CODE EST UTICA ST RSBURG, IN47172			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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